CHAPTER 2: THE ASSESSMENT SCHEDULE FOR THE RAI

This chapter presents the instructions for the completion of the mandated clinical and Medicare assessments in nursing facilities.

2.1 Introduction to the OBRA Assessment Schedule for the MDS

INTRODUCTION TO THE OBRA ASSESSMENT SCHEDULE

The OBRA regulations have defined a schedule of assessments that will be performed for a nursing facility resident at admission, quarterly, and annually, whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment. These are known as "OBRA assessments." MDS assessments are also required for Medicare payment purposes and are discussed in detail in Section 2.6.

When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. When combining OBRA and Medicare assessments, the most stringent requirement for MDS completion must be met. It is important for facility staff to fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort.

OBRA ASSESSMENTS

When the resident is first admitted to a facility, the RN Assessment Coordinator (RNAC) and the interdisciplinary team will agree on a period known as the observation period for the Admission assessment. The last day of this observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. In completing sections of the MDS that require observations of a resident over specified time periods such as 7, 14, or 30 days, the ARD is the common endpoint of these "look back" periods. This concept of setting the ARD is used for all assessment types. When completing the MDS, only those items that occurred during the look back period will be captured. In other words, if it did not occur during the look back period, it should not be coded on the MDS.

When all members of the team have completed their portions of the assessment and the assessment is complete, the RN Assessment Coordinator (RNAC) will sign Item R2a and will date Item R2b with the date that R2a was signed. The R2b date is the completion date for all assessment types that do not require RAPs, and is the date used to determine when the next OBRA assessment is to be completed. An OBRA assessment is due no less frequently than every 92 days.

Resident Assessment Protocols (RAPs) are reviewed following the completion of the MDS portion of the RAI for comprehensive assessments in order to identify the resident's strengths, problems, and

needs. This decision-making process is documented on the Resident Assessment Protocol Summary, which is detailed in Chapter 4.

The timing requirements for a comprehensive assessment apply to both completion of the MDS (R2b) and the completion of the RAPs (VB2). For example, an Admission assessment must be completed within 14 days of admission. This means that both the MDS and the RAPs (R2b and VB2 dates) must be completed by day 14. The MDS Completion Date (R2b) may be earlier than or the same as the RAPs Completion Date (VB2), and neither can be later than day 14.

The comprehensive RAI is considered complete on the date the RN Coordinator indicates completion of the RAPs (VB2). The care plan must be completed by the end of the 7th day following completion of the RAI assessment. In other words, 7 days following the VB2 date.

Assuming the resident does not have any significant changes in status or is not discharged from the facility, the next assessment in the OBRA assessment schedule is the Quarterly assessment. The Quarterly assessment is to be completed within 92 days of the R2b date of the Admission assessment. The OBRA schedule would continue with another Quarterly assessment to be completed within 92 days of the R2b of the previous Quarterly. A third Quarterly is completed within 92 days of the completion (R2b)of the previous Quarterly.

Following the third Quarterly, and within a year of the Admission assessment, an Annual assessment is completed. This is a comprehensive assessment that requires a full MDS with RAPs and care plan review.

This cycle (comprehensive assessment – Quarterly – Quarterly - Quarterly assessment - comprehensive assessment) would repeat itself annually for a resident who never experienced a significant change or discharge.

However, residents do experience significant changes, are discharged and are readmitted to facilities. Therefore, OBRA regulations have defined a comprehensive assessment that a facility completes in the event of a significant change in status that includes RAP review and care plan revision. When a resident is discharged from a facility, a Discharge Tracking form may be required. When a resident who was discharged returns to a facility, a Reentry Tracking form may be required. The Significant Change in Status assessment, and the Discharge and Reentry Tracking forms, including their impact on the assessment schedule are discussed in more detail later in this chapter.

A comprehensive assessment is also required when the facility has identified a major error in a previously submitted comprehensive assessment. A Significant Correction of a Prior Full assessment (SCPA) must be completed within 14 days of the identification of the error. A major error is one where the resident's overall clinical status is not accurately represented on the MDS, has not been addressed in a subsequent assessment, nor addressed in the resident's care plan. Because this is a comprehensive assessment, completion of the full MDS, RAPs and the RAPs Summary is required.

Section 2.2 of this chapter examines each of the OBRA assessments and provides detailed information on the completion requirements. The following table summarizes the different types of Federally mandated assessments.

TYPE OF ASSESSMENT	TIMING OF ASSESSMENT	REGULATORY REQUIREMENT CMS "F" TAG
Admission (Initial) Assessment (Comprehensive)	Must be completed (VB2) by the 14th day of the resident's stay.	42 CFR 483.20 (b)(4)(i)/F 273
Annual Reassessment (Comprehensive)	Must be completed (VB2) within 366 days of the most recent comprehensive assessment.	42 CFR 483.20 (b)(4)(v)/F 275
Significant Change in Status Reassessment (Comprehensive)	Must be completed (VB2) by the end of the 14th calendar day following determination that a significant change has occurred.	42 CFR 483.20 (b)(4)(iv)/F 274
Quarterly Assessment (State mandated subset or MPAF)	Set of MDS items, mandated by State (contains at least CMS established subset of MDS items). Must be completed every 92 days.	42 CFR 483.20 (b)(5)/F 276
Significant Correction of a Prior Full Assessment	Completed (VB2) no later than 14 days following determination that a significant error in a prior full assessment has occurred.	42 CFR 483.20/F 287
Significant Correction of a Prior Quarterly Assessment	Completed (R2b) no later than 14 days following determination that a significant error in a prior Quarterly assessment has occurred.	42 CFR 483.20/F 287

The MDS is also completed for the Medicare Prospective Payment System. The Medicare schedule is discussed in detail in Section 2.5

2.2 Required OBRA Assessments for the MDS

ADMISSION ASSESSMENTS

The Admission assessment is a comprehensive assessment for a new resident that must be completed within 14 calendar days of admission to the facility if:

- this is the resident's first stay,
- the resident has just returned to the facility after being discharged prior to the completion of the initial assessment, or
- the resident has just returned to the facility after being discharged as return not anticipated.

The 14-day calculation includes weekends. When calculating when the RAI is due, the day of admission is counted as Day "1". For example, if a resident is admitted at 8:30 a.m. on Wednesday

(Day 1), a completed RAI is required by the end of the day Tuesday (Day 14), 13 days after admission. If a resident dies or is discharged within 14 days of admission, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.[1] In closing the record, the facility may wish to note why the RAI was not completed.

The interdisciplinary team may start and complete the initial assessment at any time prior to the end of the 14th day. If desired by the facility, the MDS could be completed in entirety on the day of admission. However, this requires the staff to rely on resident and family reporting of information and transfer documentation to a large degree as a source of information on the resident's status during the time periods used to code each MDS item, as opposed to allowing a period for facility observation. Facilities may find early completion of the MDS and RAPs particularly beneficial for individuals with short lengths of stay, when the assessment and care planning process is often accelerated.

EXAMPLES

Miss A is admitted on Friday, September 1. Staff establish the Assessment Reference Date as September 8, which means that September 8 is the final day of the observation period for all MDS items (i.e., count back 6 days before the ARD to determine the period of observation for 7-day items, count back 13 days before the ARD for 14-day items, and so on). As this is an initial assessment, staff must rely on the resident and family's verbal history and transfer documentation accompanying Miss A to complete items requiring longer than a 7-day period of observation. Staff completes the MDS by September 12 (note that the Assessment Reference Date (A3a) does not need to be the same as the date RN Assessment Coordinator signed as complete (R2b). Staff takes an additional 2 days to assess the resident using triggered RAPs and to complete all related documentation, which is noted as a date field that accompanies the signature of the RN Coordinator for the RAP assessment process on the RAP Summary form (VB2).

If a resident goes to the hospital and returns during the 14-day assessment period and most of the initial assessment was completed prior to the hospitalization, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in status. In this case, the Assessment Reference Date remains the same and the Admission comprehensive assessment must be completed by day 14 counting from the original date of admission. Otherwise the assessment should be reinitiated with a new Assessment Reference Date and completed within 14 days after readmission from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.

[1]The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

***Assessment Management Tips*: ADMISSION COMPREHENSIVE ASSESSMENT**

	Assessment Reference Date (ARD)	7-day Observation Look Back	14- day Observation Look Back	RAPs Completion Date (VB2)
ADMISSION	No later than admission date + 13 days	Consists of ARD + 6 previous calendar days	Consists of ARD + 13 previous calendar days	No later than admission date + 13 days

- The above chart summarizes how to count the days for various points within the admission assessment. As stated previously, the date of admission is Day 1 for determining when the assessment must be completed and for setting the Assessment Reference Date. Once the ARD has been established, then the ARD is day 1 whenever counting back for those items observed over a specific time period.

- Both the MDS Completion Date (R2b) and RAPs Completion Date (VB2) must be dated within 14 days of admission. R2b must always be earlier than or the same as VB2. If R2b is dated prior to day 14, VB2 may or may not be the same day, but can be no later than day 14.

- Care Plan Completion Date (VB4) must be dated by the end of the 7th calendar day following VB2 (VB2 + 7 days) and can be no later than day 21.

- Electronic submission is due within 31 days following VB4 (VB4 + 31 days).

ANNUAL REASSESSMENTS

The annual comprehensive assessment must be completed within 366 days of the completion date at VB2 of the most recent comprehensive assessment (could be the Admission assessment, an Annual assessment, a Significant Change in Status assessment or a Significant Correction of a Prior Full assessment). If a significant change reassessment is completed in the interim, the clock "restarts," and the Annual assessment would be due within 366 days of the significant change reassessment. Routinely scheduled RAI assessments may be scheduled early if a facility wants to stagger due dates for assessments.

In managing the dates for the Annual assessment, the anticipated completion date of the assessment to be scheduled as well as the completion dates of the previous comprehensive and Quarterly assessments must be considered when setting the ARD. The completion date of the Annual assessment must meet two requirements: 1) a comprehensive assessment must be completed within 366 days of the RAPs Completion Date (VB2) of the previous comprehensive, and 2) there can be no more than 92 days since the (MDS Completion Date (R2b) of the last Quarterly assessment.

If a significant change in status is identified in the process of completing an Annual assessment, code the assessment as a Significant Change in Status assessment. Do not code it as an Annual assessment.

<u>Assessment Management Tips</u>: ANNUAL COMPREHENSIVE REASSESSMENT

	Assessment Reference Date (ARD)	**7-day Observation Look Back**	**14- day Observation Look Back**	**RAPs Completion Date (VB2)**
ANNUAL	**<u>No later than:</u>** RAPs Completion Date (VB2) of previous OBRA comprehensive assessment + 366 days **<u>AND</u>** MDS Completion Date (R2b) of previous OBRA assessment + 92 days	Consists of ARD + 6 previous calendar days	Consists of ARD + 13 previous calendar days	ARD + 14 days **<u>BUT</u>** **<u>No later than:</u>** RAPs Completion Date (VB2) of previous OBRA assessment + 366 days **<u>AND</u>** MDS Completion Date (R2b) of previous OBRA assessment + 92 days

- The Annual assessment must be completed no later than 14 days after the ARD. That is, R2b and VB2 can be no more than 14 days from the ARD (ARD + 14 days). Since the ARD is part of the observation period, it is considered day 0, and is not included in calculating the 14-day completion period. VB2 is not required to be the same day as R2b but can be no later than 14 days following the ARD.

- Once the ARD has been established, it is the last day of the observation period.

- Care Plan Completion Date (VB4) must be dated by the end of the 7th calendar day following VB2 (VB2 + 7 days) and can be no later than 21 days following the ARD.

- Electronic submission is due within 31 days following VB4 (VB4 + 31 days).

SIGNIFICANT CHANGE IN STATUS ASSESSMENTS (SCSA)-Comprehensive Assessment

Facilities have an ongoing responsibility to assess resident status and intervene to assist the resident to meet his or her highest practicable level of physical, mental, and psychosocial well-being. If interdisciplinary team members identify a significant change (either improvement or decline) in a resident's condition they should share this information with the resident's physician, who they may consult about the permanency of the change. The facility's medical director may also be consulted when differences of opinion about a resident's status occur among team members.

Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. A Significant Change in Status (SCSA) assessment is not required in a case where the resident's condition is expected to return to baseline within a short period of time, such as one to two weeks. If the condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the resident, but in no case later than 14 days after the determination was made that a significant change occurred.

An SCSA can be performed at any time after the completion of the Admission assessment. If a significant change in status is identified in the process of completing a Quarterly assessment, code the assessment as a SCSA and complete a comprehensive assessment. Do not code it as a Quarterly assessment. The SCSA restarts the schedule and the next Quarterly assessment would be due no more than 92 days from R2b of the SCSA. Similarly, if an SCSA is identified in the process of completing an Annual assessment, it should be coded as an SCSA.

A "**significant change**" is a decline or improvement in a resident's status that:

1. **Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting"**
2. **Impacts more than one area of the resident's health status; and**
3. **Requires interdisciplinary review and/or revision of the care plan.**

A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease related clinical interventions. For example, a 5% weight loss for a resident with the flu would not normally meet the requirements for a "significant change" reassessment. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required. The amount of time that would be appropriate for a facility to monitor a resident depends on the clinical situation and severity of symptoms experienced by the resident. Generally, if the condition has not resolved within approximately 2 weeks, staff should begin a comprehensive RAI assessment. This time frame is not meant to be prescriptive, but rather should be driven by clinical judgment and the resident's needs.

An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require a significant change reassessment, unless a second area of decline accompanies it. Note that this answer assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and if the problem persists or worsens, a comprehensive RAI reassessment may be clinically indicated.

If there is only one change, however, staff may still decide that the resident would benefit from an SCSA. It is important to remember that each resident's situation is unique and the interdisciplinary treatment team must make the decision as to whether or not the resident will benefit from an RAI.

Other conditions may not be permanent but would have such an impact on the resident's overall status that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns). Changes in the resident's condition that would affect the resident's functional capacity and day-to-day routine should be investigated in a holistic manner through the RAI reassessment. Therefore, concepts associated with significant change are "major" or "appears to be permanent," but a change does not necessarily need to be both major and permanent.

An SCSA is appropriate if there is a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement). Any determination about whether or not a resident has experienced a significant change in status is a clinical decision. When a SCSA is completed, the facility must review all of the RAPs because they are interrelated. If there are no changes in a RAP, they can then document that there were no changes and bring that RAP forward and specify where the supporting documentation can be located in the medical record.

GUIDELINES FOR DETERMINING SIGNIFICANT CHANGE IN RESIDENT STATUS (Please note this is not an exhaustive list.)

The final decision regarding what constitutes a significant change in status must be based upon the judgment of the clinical staff and the guidelines shown below.

Decline in two or more of the following:

- Resident's decision-making changes from 0 or 1 to 2 or 3 for Item B4;
- Emergence of sad or anxious mood pattern as a problem that is not easily altered (Item E2);
- Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1"s for Item E4B);

- Any decline in an ADL physical functioning area where a resident is newly coded as 3, 4, or 8 (Extensive assistance, Total dependency, Activity did not occur) for Item G1A;
- Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4 (Item H1a or b), or there was placement of an indwelling catheter (Item H3d);
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days) (Item K3a);
- Emergence of a pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher (Item M2a);
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before (Items P4c and e);
- Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision-making) (Item Q2 = 2);
- Emergence of a condition or disease in which a resident is judged to be unstable (Item J5a).

EXAMPLE

Mr. T no longer responds to verbal requests to alter his screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to resist his daily care, pushing staff away from him as they attempt to assist with his ADLs. This is a significant change and reassessment is required since there has been deterioration in the behavioral symptoms to the point where it is occurring daily and new approaches are needed to alter the behavior. Mr. T's behavioral symptoms could have many causes, and reassessment will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Mr. T's disruptive behavior.

Improvement in two or more of the following:

- Any improvement in an ADL physical functioning area where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8 (Item G1A);
- Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered" (Items E2 and E4B);
- Resident's decision-making changes from 2 or 3 to 0 or 1 (Item B4);
- Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1 (Item H1a or b);
- Overall improvement of resident's condition; resident receives fewer supports (Item Q2 = 1).

EXAMPLE

Mrs. G has been in the facility for 5 weeks, following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or agitated. The resident, her family, and staff agree that she has made remarkable progress. A reassessment is required at this time. The resident is not the person she was at admission; her initial problems have resolved. Reassessment will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

While a facility may choose to perform more frequent comprehensive assessments than mandated by CMS, reassessments are not required for minor or temporary variations in resident status. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary clinical interventions, even though a reassessment is not required. In these cases the resident's condition is expected to return to baseline within a short period of time, such as 1-2 weeks.

GUIDELINES FOR WHEN A CHANGE IN RESIDENT STATUS IS NOT SIGNIFICANT (Please note this is not an exhaustive list)

- Discrete and easily reversible cause(s) documented in the resident's record and for which the interdisciplinary team can initiate corrective action (e.g., an anticipated side effect of introducing a psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require a significant change reassessment).

- Short-term acute illness, such as a mild fever secondary to a cold from which the interdisciplinary team expects the resident to fully recover.

- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a significant change assessment).

- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.

- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

GUIDELINES FOR DETERMINING THE NEED FOR AN SCSA FOR RESIDENTS WITH TERMINAL CONDITIONS

The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual. If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration, an SCSA assessment is required. Similarly, if the resident enrolls in a hospice (Medicare Hospice program or other structured hospice program), but remains a resident at the facility, an SCSA should be performed if the terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration. The facility is responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.

If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing facility and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The need to complete an SCSA will depend upon the resident's status at the time of election of hospice care, and whether or not the resident's condition requires a new assessment. Because a Medicare-certified hospice must also conduct an assessment at the initiation of its services, this is an appropriate time for the nursing facility to evaluate the MDS information to determine if it reflects the current condition of the resident. The nursing facility and the hospice's plans of care should be reflective of the current status of the resident.

- Complete an SCSA for a newly diagnosed resident with end-stage disease when:

  - a change is reflected in more than one area of decline; and
  - the resident's status will not normally resolve itself; and
  - the resident's status requires interdisciplinary review and/or revision of the care plan.

- Complete subsequent SCSA's based upon the degree of decline and the impact upon the comprehensive care plan. Consider the following criteria:

  - completion date of the last MDS;
  - clinical relevancy and accuracy of the MDS to the resident's current status; and
  - the need to change the resident's care plan to reflect the current status.

EXAMPLES

Mr. M has been in this facility for two and one-half years. He has been a favorite of staff and other residents and his daughter has been an active volunteer on the unit. Mr. M is now in the end stage of his course of chronic dementia - diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family members are fully aware of his status. He is on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, Mr. M's care is of a high quality, and as his physical state has declined, there is no need for staff to complete a new MDS assessment for this bed bound, highly dependent terminal resident.

Mrs. K came into the facility with identifiable problems and has steadily responded to treatment. Her condition has improved over time and plateaued. She will be discharged within 5 days. The initial RAI helped to set goals and start her care. The course of care provided to Mrs. K was modified, as necessary, to ensure continued improvement. The interdisciplinary team's treatment response reversed the causes of the resident's condition. A reassessment need not be completed in view of the imminent discharge. **Remember, facilities have 14 days to complete a reassessment once the resident's condition has stabilized, and if Mrs. K is discharged within this period, a new assessment is not required. If the resident's discharge plans change or if she is not discharged, a reassessment is required by the end of the allotted 14-day period.**

Mrs. P, too, has responded to care. Unlike Mrs. K, however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff is on top of the situation, and there is nothing to be gained by requiring an MDS reassessment at this time. However, if her condition was to stabilize and her discharge was not imminent, a reassessment would be in order.

***Assessment Management Tips*: SIGNIFICANT CHANGE IN STATUS ASSESSMENT**

	Assessment Reference Date (ARD)	7-day Observation Look Back	14- day Observation Look Back	Assessment Completion Date (VB2)
SIGNIFICANT CHANGE IN STATUS	**No later than:** 14 days following determination that a significant change has occurred	Consists of ARD + 6 previous calendar days	Consists of ARD + 13 previous calendar days	ARD + 14 days **BUT** **No later than:** the end of the 14th calendar day following determination that a significant change has occurred.

- The Significant Change in Status assessment must be completed no later than the ARD + 14 days. That is, the MDS Completion Date (R2b) and the RAPs Completion Date (VB2) can be no more than 14 days following the ARD. However, the requirement that the assessment be completed by the end of the 14th day following the determination that a significant change has occurred overrides this.

- Once the ARD has been established, it is the last day of the observation period.

- Care Plan Completion Date (VB4) must be dated by the end of the 7th calendar day following RAPs Completion Date (VB2) (VB2 + 7 days) and can be no later than 21 days following the ARD.

- Electronic submission is due within 31 days following Care Plan Completion Date (VB4) (VB4 + 31 days).

- If the significant change has been identified in the course of completing either a Quarterly assessment or an Annual reassessment, then the SCSA must be completed no later than 92 days from the previous OBRA assessment and 366 days from the previous comprehensive assessment.

SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT

A Significant Correction of Prior Full assessment (SCPA), including the full MDS form, RAPs and care plan review, is completed when an uncorrected major error is discovered in a prior comprehensive assessment. An error is major when the resident's overall clinical status has been miscoded on the MDS and/or the care plan derived from the erroneous assessment does not suit the resident. A major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan. A Significant Correction of a Prior Full assessment is appropriate after a comprehensive assessment has been accepted into the State MDS database, or when a major error has been identified in a comprehensive assessment that has been completed but is no longer in the editing and revision time period (later than 7 days following VB4). This could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected. It is not necessary to complete a new Significant Correction of Prior Full assessment if another, more current assessment has just been completed or is in progress and includes a correction to the item(s) in error.

A Significant Correction of a Prior Full assessment uses a new observation period (as defined by a new Assessment Reference Date). A significant correction assessment (not the original assessment that it corrects) drives the due date of the next assessment.

When the assessment in error has already been accepted by the MDS system at the state, the facility should also correct the assessment that was in error by completing and submitting a correction request for the erroneous assessment, in addition to completing a new assessment, the Significant Correction of a Prior Full assessment. See Chapter 5 for detailed information on processing corrections. It is necessary to correct the erroneous assessment that resides in the State MDS database in order to ensure that accurate information is available for reports that consider historic MDS information, such as incidence reporting for Quality Indicators.

The Significant Correction of a Prior Full assessment differs from a Significant Change in Status assessment, in which there has been an actual significant change in the resident's health status. In any instance in which a resident experiences a significant change in status, regardless of whether or not there was also an error on the previous assessment, the primary reason for assessment should be coded as a significant change in status. In the event of a significant change in status where there are also errors in a prior assessment already accepted into the State MDS database, the facility should also correct the assessment that was in error by completing and submitting a correction request for that erroneous assessment, in addition to completing a Significant Change in Status assessment.

***Assessment Management Tips:* SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT**

	Assessment Reference Date (ARD)	7-day Observation Look Back	14- day Observation Look Back	RAPs Completion Date (VB2)
SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT	**No later than:** 14 days following determination that a major error in the prior full assessment has occurred	Consists of ARD + 6 previous calendar days	Consists of ARD + 13 previous calendar days	ARD + 14 days **BUT** **No later than:** the end of the 14th calendar day following determination that a major error in the prior full assessment has occurred.

- The Significant Correction of a Prior Full assessment must be completed no later than the ARD + 14 days. That is, the MDS Completion Date (R2b) and the RAPs Completion Date (VB2) can be no more than 14 days following the ARD. However, the requirement that the assessment be completed by the end of the 14th day following the determination that a major error in a prior full assessment has occurred overrides this.

- Once the ARD has been established, it is the last day of the observation period.

- Care Plan Completion Date (VB4) must be dated by the end of the 7th calendar day following RAPs Completion Date (VB2) (VB2 + 7 days) and can be no later than 21 days following the ARD.

- Electronic submission is due within 31 days following the Care Plan Completion Date (VB4) (VB4 + 31 days).

ASSESSMENTS UPON READMISSION/RETURN

If a facility has formally discharged a resident without the expectation that the resident would return, but later the resident does return (AA8a = 6, Discharged-Return Not Anticipated), this situation is considered a **new admission**. When this occurs, a new Admission assessment, including Sections AB (Demographic Information) and AC (Customary Routine), must be completed within **14 days of admission**.

If a resident returns to a facility following a temporary absence for hospitalization or therapeutic leave, it is considered a **readmission**. Facilities should evaluate a resident upon readmission to determine if a significant change in the resident's condition has occurred. In these situations, follow the procedures for Significant Change in Status assessments. It is not necessary to complete Sections AB (Demographic Information) or AC (Customary Routine) of the MDS if this information has previously been collected and entered into the resident's record. If it is determined that a resident has not experienced a Significant Change in Status, the next OBRA assessment is completed within 92 days of the completion (R2b) of the last OBRA assessment prior to the resident leaving the facility.

QUARTERLY ASSESSMENTS

Each State's RAI includes, at a minimum, CMS's required Quarterly assessment items. Not all MDS items appear on the Quarterly assessment form. However, states may add items from the core MDS on their Section S, and require completion of Sections T and/or U. If you are unsure of your State's Quarterly assessment requirements, check with your State RAI Coordinator (listed in Appendix B of the User's Manual) to determine what is required in your state.

The Quarterly assessment is used to track the resident's status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. At a minimum, three Quarterly assessments and one comprehensive assessment are required in each 12-month period. Federal requirement CFR 483.20(c) specifies that a Quarterly assessment must be conducted "not less frequently than once every three months." Timing edits in the MDS standard system count 92-day intervals because there are never more than 92 days in any consecutive three-month intervals. These 92 days are measured from the date at MDS Item R2b of one assessment to Item R2b of the next assessment.

The resident's status must be assessed for each of the key mandated items of the Quarterly assessment using the State-specified form. For information on State requirements, contact your State RAI Coordinator. In conducting Quarterly assessments, facilities must also assess any additional items required for use by the State. Based on the Quarterly assessment, the resident's care plan is revised if necessary. If a Significant Change in Status assessment was completed replacing the Quarterly, the next assessment that is required is a Quarterly assessment. The Quarterly must be completed within 92 days of Item R2b on the Significant Change in Status assessment. In other words, there can be no more than 92 days between the dates recorded at MDS Item R2b of the last to the next clinical assessment.

***Assessment Management Tips*: QUARTERLY ASSESSMENT**

	Assessment Reference Date (ARD)	7-day Observation Look Back	14- day Observation Look Back	MDS Completion Date (R2b)
QUARTERLY	**No later than:** R2b of previous OBRA assessment + 92 days	Consists of ARD + 6 previous calendar days	Consists of ARD + 13 previous calendar days	ARD + 14 days **BUT** **No later than:** 92 days from the R2b of previous OBRA assessment

- When setting the ARD for the Quarterly assessment, the anticipated completion date of the assessment to be scheduled as well as the MDS Completion Date (R2b) of the previous OBRA assessment must be considered. The completion date of the Quarterly assessment must be within 92 days of the MDS Completion Date (R2b) of the last OBRA assessment.

- If, in the course of completing the Quarterly assessment, it is determined that a significant change in status has occurred, the comprehensive Significant Change assessment must be completed instead of the Quarterly. The next Quarterly assessment would be due no more than 92 days of the R2b date of the SCSA.

- The Quarterly assessment must be completed no later than 14 days after the ARD. That is, R2b can be no more than 14 days from the ARD (ARD + 14 days).

- Once the ARD has been established, it is the last day of the observation period.

- Electronic submission is due within 31 days following the MDS Completion Date (R2b) (R2b + 31 days).

SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT

Significant Correction of a Prior Quarterly assessment is completed when an uncorrected major error is discovered in a Quarterly assessment. An error is major when the resident's overall clinical status has been miscoded on the MDS and/or the care plan derived from the erroneous assessment does not suit the resident. A major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan. A Significant Correction of a Prior Quarterly assessment is appropriate when an uncorrected major error is identified in a Quarterly assessment that has been accepted into the State MDS database, or in a Quarterly assessment that has been completed and is no longer in the editing and revision time

period (later than 7 days from R2b). This could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected. It is not necessary to complete a new Significant Correction of Prior Quarterly assessment if another, more current assessment is already due or in progress that contains and will correct the item(s) in error.

A Significant Correction of a Prior Quarterly assessment uses a new observation period (as defined by a new Assessment Reference Date). A Significant Correction of a Prior Quarterly assessment (not the original assessment that it corrects) drives the due date of the next assessment.

When the assessment in error has already been accepted by the MDS system at the State, the facility should also correct the assessment that was in error by completing and submitting a correction request for the erroneous assessment, in addition to completing a new assessment, the Significant Correction of a Prior Quarterly assessment. Refer to Chapter 5 for details regarding the CMS correction process. It is necessary to correct the erroneous assessment that resides in the State MDS database in order to ensure that accurate information is available for reports that consider historic MDS information, such as incidence reporting for Quality Indicators.

Assessment Management Tips: ***SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT***

	Assessment Reference Date (ARD)	**7-day Observation Look Back**	**14- day Observation Look Back**	**MDS Completion Date (R2b)**
SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT	**No later than:** 14 days following determination that a major error in the prior Quarterly assessment has occurred	Consists of ARD + 6 previous calendar days	Consists of ARD + 13 previous calendar days	ARD + 14 days **BUT** **No later than:** the end of the 14th calendar day following determination that a major error in the prior Quarterly assessment has occurred.

- The Significant Correction of a Prior Quarterly assessment must be completed no later than the ARD + 14 days. That is, the MDS Completion Date (R2b) can be no more than 14 days following the ARD. However, the requirement that the assessment be completed by the end of the 14th day following the determination that a significant error in a prior Quarterly assessment has occurred overrides this.

- Once the ARD has been established, it is the last day of the observation period.

2.3 RAPs and Care Plan Completion

After completing the MDS portion of the comprehensive assessment, the assessor(s) then proceed(s) to further identify and evaluate the resident's strengths, problems, and needs through use of the **Resident Assessment Protocol Guidelines (RAPs)** described in detail in Chapter 4 of this manual and through further investigation of any resident-specific issues not addressed in the RAI. For example, those items that are not automatically triggered, such as Item P4 (side rails), may require further investigation.

Completed along with the MDS, the RAPs provide the foundation upon which the care plan is formulated. There are 18 problem-oriented RAPs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review. Triggers and their definitions for each RAP appear in Appendix C. Also in Appendix C are the RAP Guidelines for additional assessment and review to determine if a care plan is appropriate to address the triggered condition.

***Assessment Management Tips*: COMPREHENSIVE ASSESSMENTS REQUIRING RAPs**

	MDS Completion Date (R2b)	RAPs Completion Date (VB2)
COMPREHENSIVE ASSESSMENTS REQUIRING RAPs	**Admission assessment:** No later than Admission date + 13 days **Annual assessment:** ARD + 14 days, but no later than R2b of previous OBRA assessment + 92 days. **Significant Change assessment:** Date of determination + 14 days **Significant Correction of a Prior Full Assessment:** Date of determination of error + 14 days	**Admission assessment:** No later than Admission date + 13 days **Annual assessment:** ARD + 14 days, but no later than VB2 of previous OBRA comprehensive assessment + 366 days. **Significant Change assessment:** Date of determination + 14 days **Significant Correction of a Prior Full Assessment:** Date of determination of error + 14 days

- MDS Completion Date (R2b) must be earlier than or the same date as the RAPs Completion Date (VB2). In no event can either date be later than the established timeframes as described above.

FORMULATION OF THE CARE PLAN

For an Admission assessment, the resident enters the facility on day 1 with a set of physician-based treatment orders. Facility staff typically reviews these orders. Questions may be raised, modifications discussed, and change orders issued. Ultimately, of course, it is the attending physician who is responsible for the orders at admission, which form the basis for care plan development.

On day 1, facility staff also begins to assess the resident and to identify problems. Both activities provide the core of the MDS and RAP process, as staff look at issues of safety, nourishment, medications, ADL needs, continence, psychosocial status and so forth. Facility staff determines whether or not there are problems that require immediate intervention (e.g., providing supplemental nourishment to reverse weight loss or attending to a resident's sense of loss at entering the nursing facility). For each problem, facility staff will focus on causal factors and implement an initial plan of care based on their understanding of factors affecting the resident.

The MDS and RAPs provide the clinician with additional information to assist in this preliminary care planning process. The MDS ensures that staff has timely access to a wide range of assessment data. The RAPs provide criteria that trigger review of possible problem conditions to ensure that staff identifies problems in a consistent and systematic manner. Use of the RAP Guidelines helps ensure that the full range of relevant causal factors is considered.

If the admission MDS is not completed until the last date possible (i.e., at the end of calendar day 14 of the residency period), interventions will already have been implemented to address priority problems. Many of the appropriate RAP problems will have been identified, causes will have been considered, and a preliminary care plan initiated. The final care plan is then required no later than 7 days after the RAI assessment is completed.

For triggered problems that have already resulted in a care plan intervention, the final RAP review will ensure that all causal factors have been considered. For RAP conditions for which facility staff has not yet initiated a care program, the RAP review will focus on whether or not these conditions are, in fact, problems that require facility intervention. For any triggered problem, staff will apply the RAP Guidelines to evaluate the resident's status and determine whether or not a situation exists that warrants care planning. If it does, the RAP Guidelines will next be used to help identify the factors that should be considered for developing the care plan.

For an Annual reassessment or a Significant Change in Status assessment, the process is basically the same as that described for newly admitted residents. In these cases, however, the care plan will already be in place, and staff is unlikely to be actively instituting a new approach to care as they simultaneously complete the MDS and RAPs. Here, review of the RAPs when the MDS is complete will raise questions about the need to modify or continue services. The condition that originally triggered the RAP may no longer be present because it was resolved, or consideration of alternative causal factors may be necessary because the initial approach to a problem did not work, or was not fully implemented.

Clarification:

- The RAI was not designed to identify every conceivable problem that a resident might experience. An example of this is "chewing problem" at MDS

Item K1a. Although the resident might have a chewing problem, checking this problem does not trigger a RAP. Clinical judgment must be exercised in the identification of problems and potential problems in developing the plan of care. In ensuring that a resident's care plan is unique and specific to the resident, it is not sufficient to rely solely on the triggered RAPs. Another example of this is "side rails" at MDS Item P4. Although the resident may use side rails, this item does not automatically trigger a RAP.

CARE PLAN COMPLETION

Facilities have 7 days after the completion of the RAI assessment to develop or revise the resident's care plan. The RN coordinator should sign and date the RAP Summary form after all triggered RAPs have been reviewed to certify completion of the comprehensive assessment (RAPs Completion Date, VB1 and VB2). Facilities should use this date to determine the date by which the care plan must be completed.

The 7-day requirement for completion or modification of the care plan applies to the Admission, Significant Change in Status, Significant Correction of a Prior Full assessment, or Annual RAI assessment. A new care plan does not need to be developed after each SCSA, Significant Correction of a Prior Full assessment, or Annual reassessment. Rather, the facility may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan after each Quarterly assessment and modify the care plan if necessary. (See Chapter 4 for more information on care planning.)

Clarification:

- The care plan should be revised on an on-going basis to reflect changes in the resident and the care the resident is receiving. The care plan is an interdisciplinary communication tool. Review 42 CFR 483.20(d), Comprehensive Care Plans. The comprehensive care plan must include measurable objectives and time frames, and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be periodically reviewed and revised, and the services provided or arranged must be in accordance with each resident's written plan of care. Refer to the SOM Transmittal #274, (F Tag 279), "The results of the assessment are used to develop, review and revise the resident's comprehensive plan of care."